MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC

Requestor's Name and Address SAN ANTONIO ORTHOPAEDIC SURGERY CENTER 400 Concord Plaza Suite 200 San Antonio, TX 78216	MDR Tracking No.: M4-05-0766-01 TWCC No.: [redacted] Injured Employee's Name: [redacted]
Respondent's Name and Address **Rep Box 15** INDEMNITY INSURANCE CO OF NORTH 3421 W William Cannon Drive STE 131 PMB # 113 Austin, TX 78745-5022	Date of Injury: [redacted] Employer's Name: [redacted] Insurance Carrier's No.: 4650174296

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
05-17-04	05-17-04	29827 RT	$7,437.40	$2,079.30
05-17-04	05-17-04	29824 RT	$7,551.20	$1,039.65
05-17-04	05-17-04	29826 RT	$7,698.01	$739.50
			Total Amount Paid:	**(-$1,944.39)**
			Remainder Due:	**$1,914.06**

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's Rationale for increased reimbursement or refund submitted on the TWCC 60 indicates, "The Carrier has not provided the proper payment exception code in this instance, which is in violation of the Texas Administrative Code. Carrier did not make "fair and reasonable" reimbursement and did not make consistent reimbursements." Letter from Requestor received 10-22-04 indicated, "...Our charges are fair and reasonable. Applying some other non-ASC calculations into the determination of fair and reasonable on your part is neither fair nor reasonable since there is no correlation to these non-ASC non-workers compensation calculations. We ask that you provide us with an additional reimbursement for the date of this service."

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent's Rationale for maintaining the Reduction or denial submitted on the TWCC 60 indicated that, "The provider has failed to meet it's burden of proof to establish that it's charges and the amounts requested are "fair and reasonable", and comply with Section 413.011(b) of the Texas Labor Code and Commission rules. The Carrier's reimbursement complies with the requirements of Section 413.011(b) of the Texas Labor Code and Commission rules, and is "fair and reasonable."

An Explanation of Review submitted by Broadspire Services for the Carrier indicated the following explanation: Code 866 – ASC reimbursement is based on fees established to be fair and reasonable in your geographical area; M – No MAR, and 900-999 Based on further review, no additional payment is warranted.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

After reviewing the documentation provided by both parties, it appears that neither party has provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307). After reviewing the services, the charges, and both parties' positions, it is clearly evident

that some other amount represents the fair and reasonable reimbursement.
During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 213.3% to 290% of Medicare for this particular year-2004). Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review, staff selected a reimbursement amount in the high end of the Ingenix range. In addition, the reimbursement for the secondary procedures was reduced by 50%, consistent with standard reimbursement approaches. The total amount was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the recommended amount, discussed the facts of the individual case, and selected the appropriate "fair and reasonable" amount to be ordered in the final decision.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that the fair and reasonable reimbursement amount for these services is $3,858.45. Since the insurance carrier paid a total of $1,944.39 for these services, the health care provider is entitled to an additional reimbursement in the amount of $1,914.06.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$1,914.06.** The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Amy L. Rich Typed Name	8/4/05 Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005 should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: 8/5/05